INTEGRATED BILLING
INGENIX CLAIMSMANAGER™ INTERFACE

TECHNICAL MANUAL

IB Version 2.0
Patch IB*2.0*161

May 3, 2002

Department of Veterans Affairs
V*IST***A** Technical Services
Prepared by DAOU Systems, Inc.

Preface

This is the Technical Manual for the Integrated Billing (IB) software package's Ingenix ClaimsManager™ Interface which will be introduced as Patch IB*2.0*161. It is designed to assist IRM personnel in the operation and maintenance of the interface.

For information regarding use of the software, please refer to the Integrated Billing User Manual and the Integrated Billing Ingenix ClaimsManager™ Interface User Manual.

For information on the installation of this interface, please refer to the Integrated Billing Ingenix ClaimsManager™ Interface Installation Guide.

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Introduction

This release of Integrated Billing patch IB*2.0*161 will introduce fundamental changes to the flow of data when processing third party professional claims with the HCFA 1500 form type.

This interface was planned and designed to be a Class I initiative with the coordination and assistance of the national IB team.

The goal, to interface a COTS product, designed to check professional claims for errors before the claim is authorized. The product is ClaimsManager, designed and marketed by INGENIX, 2525 Lake Park Blvd., West Valley City, UT 84120.

The interface between the existing IB software and the Ingenix ClaimsManager system was provided by the Technology Services Division of DAOU Systems Inc, 10410 N. Kensington Parkway, Kensington, MD 20895.

The interface has been designed to be as transparent as possible to the user involved in the billing process. When the claim has passed the IB edits, and all national checks, it will automatically be sent to the Ingenix ClaimsManager system. If no errors are found, the user may then complete the process and authorize the bill. If errors are found, the user is informed and allowed to edit the bill and correct the errors. If the user holds the IBCI OVERRIDE security key, they will be allowed to override the errors and authorize the bill without correcting the errors. The user will also have the capability of "test sending" the claim at anytime during the edit process to see if it would pass the ClaimsManager checks without errors. In claims in which errors were found the user will have the capability of assigning the bill to another user. If the user does not hold the IBCI CLAIMSMANAGER ASSIGN key they will be limited to assigning only bills that are already assigned to them or have never been assigned. If the claim is assigned to someone other than the biller making the assignation, it will generate a mail message to the user to whom it has been assigned informing him/her of the assignation.

Additional functionality has been added for reports and for editing the site parameters specific to the interface, as well as processing of claims that were edited during periods of communication failure or when the ClaimsManager server was down.

Online help is provided at all prompts by typing one or two question marks.

Orientation

The Integrated Billing – Ingenix ClaimsManager Interface Technical Manual is divided into major sections for clarity and ease of use. This manual is intended for use as a reference document by technical computer personnel

The Implementation and Maintenance Section provides information on any aspect of the interface that is site configurable. The Files section shows the relationships between the files added for the interface and the existing IB files. This section also contains a listing of each IB input template that has been modified for this interface. External Interfaces (Ingenix ClaimsManager Components) will address the ClaimsManager Server and it's requirements. List Manager Component explains the use of the List Manager in the interface. Internal Relations addresses namespacing and variable use.

Note to Users with Qume Terminals

It is very important that you set up your Qume terminal properly. After entering your access and verify codes, you will see

Select TERMINAL TYPE NAME: {type} //

Please make sure that <C-QUME> is entered here. This entry will become the default. You can then press <RET> at this prompt for all subsequent log-ins. If any other terminal type configuration is set, options using the List Manager utility will neither display nor function properly on your terminal. The reports and error messaging system in the interface makes extensive use of the List Manager functions.

Who Should Read this Manual?

This manual is intended for technical IRM personnel who may be called upon to install and support this software.

Symbols

The following are explanations of the symbols used throughout this manual.

<RET>	Press the RETURN or ENTER key.
<SP>	Press the SPACEBAR.
<^>	Up-arrow, which you enter by pressing the SHIFT key and the numeric 6 key simultaneously.
<?> <??> <???>	Enter single, double, or triple question marks to activate on-line help depending on the level of help you need.

Implementation and Maintenance

Package Requirements

V*ISTA* Package and Version	Associated Patch Designation(s)	Brief Patch Description
Integrated Billing Version 2.0		
	IB*2.0*128	FIXES TO DIAGNOSTIC MEASURES RPTS
	IB*2.0*137	EDI
	IB*2.0*151	BUG FIXES TO IB

Site Parameters

The following fields have been added to the IB SITE PARAMETER file # 350.9:

Field Number	Field Name
50.01	RUNNING CLAIMSMANAGER?
50.02	CLAIMSMANAGER WORKING OK?
50.03	GENERAL ERROR MSG MAIL GROUP
50.04	COMM ERR MSG MAIL GROUP
50.05	CLAIMSMANAGER TCP/IP
50.06	CLAIMSMANAGER PORTS (Multiple)
50.07	MAILMAN MESSAGE FLAG (PRIORITY or NORMAL)

Mail Group Name	Description
IBCI GENERAL ERROR	This Mail Group receives message when claims are sent from the Multiple Send option and errors are found.
IBCI COMMUNICATION ERROR	This Mail Group receives messages when there is a communications failure in the transmission to the Ingenix ClaimsManager Server.

Routines

Per VHA Directive 10-93-142 regarding security of software that affects financial systems, most of the IB routines may not be modified. This restriction will be noted on the third line of the routines.

Callable Routines

NOW^IBCIUT1	This tag is called to get the current date/time (or user specified date/time) and convert it to ClaimsManager format. Input variable is X but if X is undefined, it will get the current date/time and use that. Output variable is Y and will be returned in ClaimsManager format (yyyymmdd) or (yyyymmddhhmmss).
$$NOW1^IBCIUT1(X)	This function will convert a date from (mmddyyyy) to (yyyymmdd).
NAMSP^IBCIUT1	This tag is called to split a name into three pieces. Input variable is X in the format X=LAST,FIRST MIDDLE. Output variable is Y in the format Y=LAST^FIRST^MIDDLE.
$$CM^IBCIUT1(IBIFN)	This extrinsic function will return a "1" if ClaimsManager is running (see $$CK0) and if the bill number passed in is a HCFA 1500 claim (see $$CK1).
$$CK0^IBCIUT1()	This extrinsic function will return a "1" if ClaimsManager is running on the Vista System. This is determined by a check to the RUNNING CLAIMSMANAGER field of the IB SITE PARAMETERS file.
$$CK1^IBCIUT1(IBIFN)	This function will return a "0" (zero) if it is a HCFA 1500 claim and will return a "1" if any other form type.
$$CK2^IBCIUT1()	This function checks to see if ClaimsManager is working OK. If running okay, it will return a 1. This is determined by a check to the CLAIMSMANAGER WORKING OK? field in the IB SITE PARAMETERS file.
ST^IBCIUT1(IBCIST)	This tag will change the status field in file 351.9 to the value contained in the input variable IBCIST.
$$STAT^IBCIUT1(IBIFN)	This function will return the value of the status field in 351.9.
$$LITMS^IBCIUT1(IBIFN)	This function returns the number of Line Items.
ERR^IBCIUT1	This tag will display an error message contained in the IBCIER1 variable.
$$LSTA^IBCIUT1(IBCISNT)	This function will return the line status needed for the ClaimsManager message based on the input variable of IBCISNT. If IBCISNT=5, the line status will be set to "P" for profiled. If IBCISNT=4, the line status will be set to "D" for deleted. If IBCISNT=7, the line status will also be set to "D" for deleted. If IBCISNT =anything else, It will set the line status to "A" for active.
$$RPHY^IBCIUT1(IBIFN)	This function returns a pieced string with the following information about the rendering or billing provider on the bill. It returns the name, provider id, department, and the specialty. For non-VA

	providers, the department is always “NVA” and the provider id is “NVA” concatenated with the IEN from file 355.93.
$$CKNER^IBCIUT1()	This function returns a “1” if the claim passed the Ingenix ClaimsManager with no errors. Returns a “0” (zero) if errors were found.
$$CKLI^IBCIUT1(IBIFN)	This function returns a “0” (zero) if there are no line items, and a value >0 if there are.
CKFT^IBCIUT1(IBIFN)	This procedure is designed to be called from the input templates that control much of the IB bill enter/edit screens. It checks for a form type change by the user. If the bill is not in file 351.9, but is a HCFA 1500, it will add it to 351.9. If it is there but is not a HCFA 1500, it will delete it. This is the action needed in case the biller changes the form type within the Bill Edit Screens. Additionally, if the bill is not currently a HCFA 1500 bill, but it has been sent to ClaimsManager previously, then a transaction with ClaimsManager will result so that the line items of this bill may be deleted on the ClaimsManager side (this is when IBCISNT=7).
DIAG^IBCIUT1(IBIFN)	This tag will return an array of diagnosis codes for each line item.
$$FILL^IBCIUT2()	This function pads the value of X with spaces or specified characters. Input variables: X = input value in non-fixed format X1 = desired length of the output (default is 80 if undefined) X2 = justify ‘R’ or ‘L’ (if undefined or not contains ‘R’ or ‘L’, Default is ‘L’) X3 = character you want X padded with (default is “ “ [space]) X4 = truncate flag, if contains ‘T’ and X>X1 it will be truncated Output variable: Y
$$ASND^IBCIUT2(IBIFN)	This function is called to send the claim identified by IBIFN to the ClaimsManager. Input variables are IBIFN and IBCISNT. The variable IBIFN is the IEN of the bill in 351.9. IBCISNT identifies where the bill was sent from. If IBCISNT=1, it is a normal send from the end of the edit screens. If IBCISNT=2, it is a normal claim sent from the Multiple Send option. If IBCISNT=3, it is a test send generated from the ?CLA functionality introduced to the edit screens. If IBCISNT=4, it is sent from the cancellation process. If IBCISNT=5, it is sent from the override process. If IBCISNT=6, it is an authorized claim sent from the Multiple Send option (for historical purposes). If IBCISNT=7, then it is a non-HCFA 1500 claim and the purpose of the transaction with ClaimsManager is to delete the line items on the claim on the ClaimsManager side.
READ^IBCIUT3(Z,PROBLEM,IBCISOCK)	This call will read the message, close and unlock the port. Data will be returned in the Z array and if there is a problem, it will be returned in the variable PROBLEM. For listing of errors returned in PROBLEM please refer to the call P1^IBCIUT4(PROBLEM). The TCP/IP port number is passed in as variable IBCISOCK. This is to be able to unlock the port when finished.

$$TRIM^IBCIUT3(X,SIDE,CHAR)	This function will trim characters from left/right of the string contained in the value of X.
CCK^IBCIUT4()	This tag checks codes for decimal points and strips them out.
DELER^IBCIUT4	This tag requires an input variable of IBIFN and will delete the error information in that entry in file 351.9.
DELTI^IBCIUT4	This tag requires the input variable of IBIFN and will delete all temporary information stored in that entry in file 351.9.
DCOM^IBCIUT4(IBIFN)	This tag will delete whatever is in the comment field in 351.9.
$$P1^IBCIUT4(PROBLEM)	This function will look at the variable PROBLEM and return the error information in the format: (error code^error description^message returned from ClaimsManager). PROBLEM = 1, TCP/IP time-out during 1st read PROBLEM = 2, Local Symbol Size problems during 1st read PROBLEM = 3, 1st read was not a ClaimsManager ACK message PROBLEM = 4, TCP/IP time-out during 2nd read PROBLEM = 5, Local Symbol Size problems during 2nd read PROBLEM = 6, 2nd read was not a RESULTREC message type PROBLEM = 99, Unable to Open Port
$$CODER^IBCIUT5(IBIFN)	This function returns the inpatient/outpatient coder of this bill. The input variable is IBIFN and the output is a string in the format: ("O" or "I"^coder's ien^coder's name).
$$BILLER^IBCIUT5(IBIFN)	This function returns the entered/edited by person for this bill. The input variable is IBIFN and the output is a string in the format: (biller's ien for file 200^biller's name).
$$TD^IBCIUT5(IBIFN)	This function returns the terminal digit for reporting purposes. Input variable is IBIFN and output is in the format: (terminal digit of ssn^ssn)
$$GETMOD^IBCIUT5(Z)	This function returns a comma delimited string of modifier codes. Input is a comma-delimited string of modifier ien's. Output is a comma-delimited string of external modifiers.
DASN^IBCIUT5(IBIFN)	This tag will delete the assigned to person field in 351.9.
CAT^IBCIUT6(IBIFN,IBCIFRM,IBCITO,IBCIGRP,GRPONLY)	This tag will send a priority or normal MailMan message when you change the assigned to person to someone other than the person assigning or someone other than the last person it was assigned to. Input variable IBIFN - IEN of claim IBCIFRM - DUZ of person assigning the claim (not returned) IBCITO - DUZ of person being assigned the claim (not returned) IBCIGRP – IEN of the Mail Group to receive this message GRPONLY – Flag indicating if the Mail Group is the only entity to receive this message

New Routines

ROUTINE FIRST LINE

```
IBCIADD1  ;DSI/SLM - ADD ENTRY TO FILE 351.9 ;17-JAN-2001
IBCIASN   ;DSI/JSR - STANDALONE OPTION TO RE-ASSIGN CLAIMS ;18-MAY-2001
IBCIBW    ;DSI/JSR - IBCI CLAIMS MANAGER MGR WORKSHEET ;6-MAR-2001
IBCICL    ;DSI/JSR - IBCI CLAIMS MANAGER CLERK WORKSHEET ;6-MAR-2001
IBCICME   ;DSI/ESG - IBCI CLAIMSMANAGER ERROR REPORT ;6-APR-2001
IBCICME1  ;DSI/ESG - IBCI CLAIMSMANAGER ERROR REPORT <CONT> ;6-APR-2001
IBCICMEP  ;DSI/JSR - ClaimsManager ERROR REPORT ;6-APR-2001
IBCICMS   ;DSI/ESG - IBCI CLAIMSMANAGER STATUS REPORT ;2-APR-2001
IBCICMSP  ;DSI/JSR - ClaimsManager STATUS REPORT ;6-APR-2001
IBCICMW   ;DSI/JSR - CLAIMSMANAGER WORKSHEET REPORT ;20-APR-2001
IBCIL0    ;DSI/ESG - CLAIMSMANAGER SKIP LIST ;11-JAN-2001
IBCIMG    ;DSI/JSR - IBCI CLAIMS MANAGER MGR WORKSHEET ;6-MAR-2001
IBCIMSG   ;DSI/SLM - BUILD MESSAGE FOR CLAIMSMANAGER ;12-JAN-2001
IBCIMSG1  ;DSI/SLM - BUILD MESSAGE FOR CLAIMSMANAGER CONT'D ;16-JAN-2001
IBCINPT   ;DSI/ESG - Extract data and create NPT file ;27-DEC-2000
IBCIPAY   ;DSI/ESG - Extract data and create Ingenix Payor File ;11-JAN-2001
IBCIPOST  ;DSI/ESG - CLAIMSMANAGER POST INSTALL ;16-OCT-2001
IBCISC    ;DSI/ESG - IB EDIT SCREENS ?CLA FUNCTIONALITY ;23-FEB-2001
IBCIST    ;DSI/SLM - ENTRY POINTS FOR CLAIMSMANAGER INTERFACE ;7-MAR-2001
IBCIUDF   ;DSI/SLM - CLAIMSMANAGER USER DEFINED FIELDS ;21-MAY-2001
IBCIUT1   ;DSI/SLM - MISC UTILITIES FOR CLAIMSMANAGER INTERFACE ;21-DEC-2000
IBCIUT2   ;DSI/SLM - CLAIMSMANAGER MESSAGE UTILITIES ;21-DEC-2000
IBCIUT3   ;DSI/ESG - TCP/IP UTILITIES FOR CLAIMSMANAGER INTERFACE ;4-JAN-2001
IBCIUT4   ;DSI/SLM - MISC UTILITIES ;29-JAN-2001
IBCIUT5   ;DSI/ESG - UTILITIES FOR CLAIMSMANAGER INTERFACE ;9-MAR-2001
IBCIUT6   ;DSI/ESG - MAILMAN UTILITIES ;22-JUN-2001
IBCIUT7   ;DSI/ESG - COMMENTS FIELD UTILITIES ;16-JULY-2001
IBCIWK    ;DSI/JSR - WORKSHEET UTILITY ;6-MAR-2001
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Modified Routines

ROUTINE FIRST LINE

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IBCB      ;ALB/MRL - BILLING BEGINNING POINT/SELECT BILL OR PATIENT ;01 JUN 88 12:00
IBCB1     ;ALB/AAS - Process bill after enter/edited ;2-NOV-89
IBCB2     ;ALB/AAS - Process bill after enter/edited ;13-DEC-89
IBCC      ;ALB/MJB - CANCEL UB-82 THIRD PARTY BILL ;14 JUN 88  10:12
IBCCC2    ;ALB/AAS - CANCEL AND CLONE A BILL - CONTINUED ;25-JAN-90
IBCSC1    ;ALB/MJB - MCCR SCREEN 1 (DEMOGRAPHICS) ;27 MAY 88 10:13
IBCSCH    ;ALB/MJB - MCCR HELP ROUTINE ;03 JUN 88 15:25
IBCSCP    ;ALB/MRL - BILLING SCREEN PROCESSOR ;01 JUN 88 12:00
IBJPS     ;ALB/MAF,ARH - IBSP IB SITE PARAMETER SCREEN ;22-DEC-1995
IBJPS1    ;ALB/MAF,ARH - IBSP IB SITE PARAMETER BUILD ;22-DEC-1995
IBJPS2    ;ALB/MAF,ARH - IBSP IB SITE PARAMETER BUILD (cont) ;22-DEC-1995
IBOSTUS   ;ALB/SGD - MCCR BILL STATUS REPORT ;25 MAY 88 14:19
IBOSTUS1  ;ALB/SGD - MCCR BILL STATUS REPORT ;25 MAY 88 14:19
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Files

Per VHA Directive 10-93-142 regarding security of software that affects financial systems, most of the IB Data Dictionaries may not be modified. The file descriptions of these files will be so noted.

Globals to Journal

The IBA global is already designated to be journalled in the Integrated Billing Technical Manual, Version 2.0. Journalling instructions from the IB Technical Manual should be followed.

File List with Descriptions

File #	File Name	Global and Description
350.9	IB SITE PARAMETERS	^IBE – This file contains the data necessary to run the IB package. It has been modified to store the parameters needed for the Ingenix ClaimsManager Interface. All data elements for the ClaimsManager Interface will be numbered 50.nn.
351.9	CLAIMSMANAGER BILLS	^IBA – This file contains information on bills that have been sent to the Ingenix ClaimsManager. The entries in this file have matching entries in the BILL/CLAIMS file (399). The internal number in file 399 is the same as the internal number in the CLAIMSMANAGER BILLS file.
351.91	CLAIMSMANAGER STATUS	^IBA - This file contains the status entries that are utilized by the ClaimsManager interface.

Templates

Following is a list of the VA FileMan templates exported

Input Templates

IB SCREEN3 FILE #399
IB SCREEN6 FILE #399
IB SCREEN7 FILE #399

Exported Options

Menus and Options

The following ClaimsManager (V*IST*A) option	is located on the following IBCI menu
Create ClaimsManager NPT File	Extract Data Files for ClaimsManager
Create ClaimsManager Payor File	Extract Data Files for ClaimsManager
ClaimsManager Error Report	ClaimsManager Reports Menu
ClaimsManager Status Report	ClaimsManager Reports Menu
Assign ClaimsManager Bill	See Site Supervisor for location.
ClaimsManager Worksheet Report	ClaimsManager Reports Menu

The following ClaimsManager (V*IST*A) option	is located on the following IB menu
Extract Data Files for ClaimsManager	System Manager's Integrated Billing Menu
ClaimsManager Reports Menu	Patient Billing Reports Menu
Multiple CLAIMSMANAGER Claim Send	Third Party Billing Menu

The following ClaimsManager (V*IST*A) option	is located on the following IB menu
Clear ClaimsManager Results Queue	IRM to attach to menu as needed

Security Keys

There are three security keys associated with the ClaimsManager interface but only one option is locked with a security key. The IBCI CM MULTIPLE CLAIM SEND security key is required to access the IBCI MULTIPLE CLAIM SEND option. The IBCI CLAIMSMANAGER OVERRIDE key is required to allow the user to override the errors found by the ClaimsManager and authorize the claim anyway. However, it is not associated with a specific option in file 19. The IBCI CLAIMSMANAGER ASSIGN key allows a user to assign any ClaimsManager Bill in file 351.9 to another user. People who don't have this key may only assign bills in this file that are currently assigned to them. This key affects only the IBCI ASSIGN CLAIMSMANAGER BILL option, however, the option is not locked with the key.

Archiving and Purging

All data associated with the ClaimsManager process is stored in the CLAIMSMANAGER BILLS file (351.9). This file is used to store both static and dynamic data. The dynamic data is deleted when the claim has completed the editing process. The amount of data stored in file 351.9 for each claim is not significant enough to require archiving and purging at this time.

External Interfaces (Ingenix ClaimsManager™ Components)

This section contains the message specifications required by the Ingenix ClaimsManager server. Please note that of the four possible types of messages that can be sent to the Ingenix ClaimsManager server, this interface is only using Claim Record (CLAIM) type. The message received back from ClaimsManager is the Claim Results (RESULTREC) message type as defined in the Ingenix documentation.

Ingenix Message Format

Internal Record and Message Format

All internal message formats may contain hybrid fixed length records that are then fit into delimited messages. The message will begin with three content delimiters and three repetition delimiters. The first content delimiter is called the segment delimiter. The second content delimiter is called the field delimiter. The third content delimiter is called the subfield delimiter. The first six characters of any message will define the delimiters for the message in the following format:
<segment delimiter><segment repetition delimiter><field delimiter>
<field repetition delimiter><subfield delimiter><subfield repetition delimiter>
This will then be followed by a string that identifies the type of message. A segment delimiter will follow the message identifier.
Message segments will consist of logical groupings of data. For example, a bill header or a bill line. Segments will be a combination of fixed strings of information and variable length delimited fields. Fields are groupings of data that are associated with a given segment. For example, a line may have one or more diagnosis codes associated with it.
Subfields are groupings of data that are associated with fields.
All internal messages will be enveloped with the ASCII SOH character (hex 01) at the beginning of the message and the ASCII ETX character (hex 03) at the end of the message.

Control Messages

ASCII SI (hex 0F) will indicate “message error” or NAK and ASCII ACK (hex 06) is “acknowledge”. ASCII NAK (hex 15) is not used. An ACK or NAK message is enveloped the same as data messages.

Data Message Types

Data Message ID’s Received by CM 3.0

- **Claim Record (CLAIM)**– Carries all claim data (for a single claim) from the host system to the rule engine to be analyzed. When the ID “Claim” is contained in the message header, the monitor will to store, analyze, and return the results for the claim data.

Data Message ID’s Sent by ClaimsManager

- **Claim Results (RESULTREC)** – This command notifies the monitor that there is a claim that needs results transmitted.

Data Message Syntax

Claim Record (CLAIM)

A claim record will consist of the following segments (curly braces indicate repeating):
MessageID
Route
Header
{Line}

Message ID Segment (single occurrence)

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
1	5			R	N	MessageID	The MessageID must be the character string “CLAIM”.

Route Segment (single occurrence)

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
1	254			R	N	SourceAddress	User’s message source address. Unused within Claims Manager, this value is returned unchanged in the result message.
2	254			R	N	ResultAddress	User’s message destination address. Unused within ClaimsManager, this value is returned unchanged in the result message.
3				R	N	**COMPLEX FIELD**	
	3	1	3	R	N	MsgType	Valid values: ‘L’ (Live Claim) or ‘T’ (Test Claim).
	16	4	19	R	N	MsgDateTime	Date and Time that the message was sent by User. If the value is NULL, ClaimsManager will use the Date and Time it received the message.
	20	20	39	R	N	MsgControlID	User supplies this unique message identifier. Claims-Manager does not use it internally and returns this value unchanged in the result message.

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
	1	40	40	R	N	MsgPriority	Valid values: 'H' (High Priority Claims) or 'L' (Low Priority Claims).
	10	41	50	R	N	UserID	If this value is NOT NULL, it will be used along with the Current Date (as set on the Monitor server machine) as the Batch ID for the batch that this record will be stored in. If this value is NULL, the 'Current Date' alone will be used as the Batch ID.
4	20			O	N	SendingApp	The sending application (e.g. User's name).
5	20			O	N	ReceivingApp	Valid value: 'ClaimsManager'.
6	30			R	N	SecurityIndicator	User supplies this indicator to specify the enterprise that owns the claim. Always used if more than one enterprise will process using a single instance of the Claims Manager database.

Header Segment (single occurrence)

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
1				R	N	**COMPLEX FIELD**	
	25	1	25	R	N	ExtBatchID	User's batch identifier.
	25	26	50	R	N	ExtBillID	User's claim or bill identifier.
	20	51	70	R	N	PatientID	User's primary patient identifier.
	20	71	90	O	N	AlternatePatientID	User's alternate patient identifier.
	40	91	130	O	N	PatientLastName	
	20	131	150	O	N	PatientMiddleName	
	20	151	170	O	N	PatientFirstName	
	16	171	186	R	N	PatientDOB	Patient's date of birth (YYYMMDD).
	1	187	187	R	N	PatientGender	Valid values: 'M' (Male), 'F' (Female), and 'U' (Unknown/ Undetermined).
	16	188	203	O	N	EntryDate/Time	Date/Time that the claim was entered in User's system (YYYYMMDDHHMMSS)

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
	20	204	223	O	N	RefPhysID	This identifier matches a physician record stored within ClaimsManager. If Claims-Manager finds no match, it will add a physician record. If this is supplied, a Department must also be present.
	40	224	263	O	N	RefPhysLName	
	20	264	283	O	N	RefPhysMName	
	20	284	303	O	N	RefPhysFName	
	5	304	308	O	N	RefPhysTitle	
	20	309	328	O	N	RefPhysDept	This identifier matches a department record stored within ClaimsManager. If ClaimsManager finds no match, it will add a default. We supply DFLT but the user may change this string during setup.
	10	329	338	O	N	RefPhysSpec	This identifier matches a specialty record stored within ClaimsManager. If Claims-Manager finds no match, it may add a specialty record.
	10	339	348	O	N	RefPhysDegreeID	
	10	349	358	O	N	RefPhysUPIN	This identifier contains the physician's UPIN number.

Line Segment (repeating)

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
1				R	N	**COMPLEX FIELD**	
	25	1	25	R	N	ExtLineID	User's transaction/line item identifier.
	20	26	45	O	N	OrgGroupID	Organization group identifier for the claim. If the value is NULL, a default value of 1 is stored.
	20	46	65	O	N	OrgID	Organization identifier for the claim. If the value is NULL, a default value of 1 is stored.
	3	66	68	R	N	LineStatus	Default values: 'A' (active), 'P' (profiled), or 'D' (deleted). User may supply values at setup.
	16	69	84	R	N	Beg_DOS	This is the beginning date of service (YYYYMMDD).
	16	85	100	R	N	End_DOS	This is the ending date of service (YYYYMMDD).
	3	101	103	R	N	POS	Place of service field.
	25	104	128	R	N	SubProcCode	Submitted procedure code.
	25	129	153	O	N	AdjProcCode	Adjusted procedure code
	15	154	168	O	N	Sub_Amt	Submitted amount.
	15	169	183	O	N	PreAuth	Pre-authorization code.
	20	184	203	O	N	Srvc_PrvID	Servicing provider identifier. This identifier matches a physician record stored within ClaimsManager. If Claims-Manager finds no match, it will add a physician record.
	40	204	243	O	N	SrvcPrvLName	
	20	244	263	O	N	SrvcPrvMName	
	20	264	283	O	N	SrvcPrvFName	
	5	284	288	O	N	SrvcPrvTitle	
	20	289	308	O	N	SrvcPrvDept	Servicing provider department. This identifier matches a department record stored within ClaimsManager. If ClaimsManager finds no match, it may add a department record.

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
	10	309	318	O	N	SrvcPrvSpec	Servicing provider specialty. This identifier matches a specialty record stored within ClaimsManager. If Claims-Manager finds no match, it may add a specialty record.
	10	319	328	O	N	SrvcPrvDegreeID	
	10	329	338	O	N	SrcvPrvUPIN	
	20	339	358	R	N	Bill_PrvID	Billing provider identifier. This identifier matches a physician record stored within ClaimsManager. If Claims-Manager finds no match, it will add a physician record. If none is supplied, a default (DFLT) is supplied. User can change this string at setup. Only one string is used for all physicians.
	40	359	398	O	N	BillPrvLName	
	20	399	418	O	N	BillPrvMName	
	20	419	438	O	N	BillPrvFName	
	5	439	443	O	N	BillPrvTitle	
	20	444	463	R	N	BillPrvDept	Billing provider department. This identifier matches a department record stored within ClaimsManager. If ClaimsManager finds no match, it may add a department record.
	10	464	473	R	N	BillPrvSpec	Billing provider specialty. This identifier matches a specialty record stored within ClaimsManager. If Claims-Manager finds no match, it will add a specialty record.
	10	474	483	O	N	BillPrvDegreeID	
	10	484	493	O	N	BillPrvUPIN	
	20	494	513	R	N	Pri_PayID	Primary Payer or FSC identifier.
	20	514	533	O	N	Sec_PayID	Secondary Payer or FSC identifier.
	3	534	536	O	N	TOS	Type of service.

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
	5	537	541	R	N	Units	Number of units for the line item.
2	20			R	Y	IcdCode	ICD code.
3	5			O	Y	Modifier	
4	0-255			O	N	UserDefinedField1	Y/N flag, indicating sensitive record.
5	0-255			O	N	UserDefinedField2	name of the Coder
6	0-255			O	N	UserDefinedField3	name of the Biller
7	0-255			O	N	UserDefinedField4	Not in use
8	0-255			O	N	UserDefinedField5	Not in use
9	0-255			O	N	UserDefinedField6	Not in use
10	0-255			O	N	UserDefinedField7	Not in use
11	0-255			O	N	UserDefinedField8	Not in use
12	0-255			O	N	UserDefinedField9	Not in use
13	0-255			O	N	UserDefinedField10	Not in use
14	0-255			O	N	UserDefinedField11	Not in use
15	0-255			O	N	UserDefinedField12	Not in use
16	0-255			O	N	UserDefinedField13	Not in use
17	0-255			O	N	UserDefinedField14	Not in use
18	0-255			O	N	UserDefinedField15	Not in use
19	0-255			O	N	UserDefinedField16	Not in use
20	0-255			O	N	UserDefinedField17	Not in use
21	0-255			O	N	UserDefinedField18	Not in use

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
22	0-255			O	N	UserDefinedField19	Not in use
23	0-255			O	N	UserDefinedField20	Not in use
24	0-255			O	N	UserDefinedField21	Not in use
25	0-255			O	N	UserDefinedField22	Not in use
26	0-255			O	N	UserDefinedField23	Not in use
27	0-255			O	N	UserDefinedField24	Not in use
28	0-255			O	N	UserDefinedField25	Not in use

Result Message (RESULTREC)

A result message will consist of the following segments (curly braces indicate repeating, and square brackets indicate optional):
MessageID
Route
[Header]
{Result Line}
{[Line]}
During the setup, the user chooses whether all lines for a claim are returned or just the lines from the most recent claim message.

Message ID Segment (single occurrence)

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
1	9			R	N	MessageID	Valid value: “RESULTREC”

Route Segment (single occurrence)

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
1	254			R	N	SourceAddress	USER supplied message source ID. ClaimsManager does not use this value and returns it unchanged from claim message.
2	254			R	N	ResultAddress	USER supplied message destination ID. ClaimsManager does not use this value and returns it unchanged from claim message.
3				R	N	**COMPLEX FIELD**	
	3	1	3	R	N	MsgType	Valid values: 'L' (Live Claim) or 'T' (Test Claim).
	16	4	19	R	N	MsgDateTime	Date and Time the message was sent by User. If the value is NULL, ClaimsManager will use the Date and Time it received the message.
	20	20	39	R	N	MsgControlID	User supplies this unique message identifier. Claims-Manager does not use it internally and returns this value unchanged from the claim message.
	1	40	40	R	N	MsgPriority	Valid values: 'H' (High Priority Claims) or 'L' (Low Priority Claims). Unchanged from claim message.
	10	41	50	R	N	UserID	User supplies this value. ClaimsManager uses this value if not-null as part of the batch ID. It is returned unchanged to the user from the claim message.
4	20			O	N	SendingApp	The claim message sending application (e.g. USER). Unchanged from claim message.
5	20			O	N	ReceivingApp	Valid value: 'ClaimsManager'.
6	30			R	N	SecurityIndicator	User supplies this indicator to specify the enterprise that owns the claim. Always used if more than one enterprise will process using a single instance of the ClaimsManager database. Unchanged from claim message.

Header Segment (single occurrence optional)

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
1				R	N	**COMPLEX FIELD**	
	25	1	25	R	N	ExtBatchID	User's batch identifier.
	25	26	50	R	N	ExtBillID	User's claim or bill identifier.
	20	51	70	R	N	PatientID	User's primary patient identifier.
	20	71	90	O	N	AlternatePatientID	User's alternate patient identifier.
	40	91	130	O	N	PatientLastName	
	20	131	150	O	N	PatientMiddleName	
	20	151	170	O	N	PatientFirstName	
	16	171	186	R	N	PatientDOB	Patient's date of birth (YYYMMDD).
	1	187	187	R	N	PatientGender	Valid values: 'M' (Male), 'F' (Female), and 'U' (Unknown/ Undetermined).
	16	188	203	O	N	EntryDate/Time	Date/Time that the claim was entered in User's system (YYYYMMDDHHMMSS)
	20	204	223	O	N	RefPhysID	This identifier matches a physician record stored within ClaimsManager. If Claims-Manager doesn't find a match, it will add a physician record. If this is supplied in the claim message, a Department must also be present in the claim message.
	40	224	263	O	N	RefPhysLName	
	20	264	283	O	N	RefPhysMName	
	20	284	303	O	N	RefPhysFName	
	5	304	308	O	N	RefPhysTitle	
	20	309	328	O	N	RefPhysDept	This identifier matches a department record stored within ClaimsManager. If ClaimsManager finds no match, it will add a default. We supply DFLT but the user may change this string during setup.

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
	10	329	338	O	N	RefPhysSpec	This identifier matches a specialty record stored within ClaimsManager. If Claims-Manager doesn't find a match, it may add a specialty record.
	10	339	348	O	N	RefPhysDegreeID	
	10	349	358	O	N	RefPhysUPIN	This identifier contains the physician's UPIN number.

Result Line Segment (repeating)

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
1				R	N	**COMPLEX FIELD**	
	25	1	25	R	N	ExtLineID	User's transaction/line item identifier.
	20	26	45	R	N	EditMnemonic	Edit code generated during analysis of this transaction. A blank value in this field indicates that no errors were found with this line.
	5	46	50	R	N	ErrorLevel	The error level for the EditMnemonic
	25	51	75	R	N	SubProcCode	Submitted procedure code.
	25	76	100	R	N	AdjProcCode	Adjusted procedure code.
	15	101	115	O	N	Sub_Amt	Submitted amount.
	15	115	130	O	N	Adj_Amt	Adjusted amount.
	1	131	131	O	N	AutoFix	Valid values: 'Y' (Yes) or 'N' (No).
	10	132	141	O	N	AutoFixType	Valid values: 'ADDPROC' (add the indicated new procedure). 'DELPROC' (delete the indicated current line procedure). 'CHGPROC' (change the current line procedure to the indicated procedure). 'ADDMOD' (add the indicated modifier to the current line). 'DELMOD' (delete the indicated modifier from the current line).

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
2	0-255			O	N	AutoFixValue	The ‘indicated value referenced from AutoFixType.
3	0-255			R	N	Action	
4	0-2000			R	N	EditDescription	The text description for the error result being reported.

Line Segment (repeating optional)

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
1				R	N	**COMPLEX FIELD**	
	25	1	25	R	N	ExtLineID	User's transaction/line item identifier.
	20	26	45	O	N	OrgGroupID	Organization group identifier for the claim.
	20	46	65	O	N	OrgID	Organization identifier for the claim.
	3	66	68	R	N	LineStatus	Valid values: 'A' (active), 'P' (profiled), or 'D' (deleted)
	16	69	84	R	N	Beg_DOS	This is the beginning date of service (YYYYMMDD).
	16	85	100	R	N	End_DOS	This is the ending date of service (YYYYMMDD).
	3	101	103	R	N	POS	Place of service field.
	25	104	128	R	N	SubProcCode	Submitted procedure code.
	25	129	153	O	N	AdjProcCode	Adjusted procedure code (unused).
	15	154	168	O	N	Sub_Amt	Submitted amount.
	15	169	183	O	N	PreAuth	Pre-authorization code.
	20	184	203	O	N	Srvc_PrvID	Servicing provider identifier. This identifier matches a physician record stored within ClaimsManager. If Claims-Manager finds no match, it will add a physician record.
	40	204	243	O	N	SrvcPrvLName	
	20	244	263	O	N	SrvcPrvMName	
	20	264	283	O	N	SrvcPrvFName	
	5	284	288	O	N	SrvcPrvTitle	
	20	289	308	O	N	SrvcPrvDept	Servicing provider department. This identifier matches a department record stored within ClaimsManager. If ClaimsManager finds no match, it may add a department record.

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
	10	309	318	O	N	SrvcPrvSpec	Servicing provider specialty. This identifier matches a specialty record stored within ClaimsManager. If Claims-Manager finds no match, it may add a specialty record.
	10	319	328	O	N	SrvcPrvDegreeID	
	10	329	338	O	N	SrcvPrvUPIN	
	20	339	358	R	N	Bill_PrvID	Billing provider identifier. This identifier matches a physician record stored within ClaimsManager. If Claims-Manager finds no match, it will add a physician record.
	40	359	398	O	N	BillPrvLName	
	20	399	418	O	N	BillPrvMName	
	20	419	438	O	N	BillPrvFName	
	5	439	443	O	N	BillPrvTitle	
	20	444	463	R	N	BillPrvDept	Billing provider department. This identifier matches a department record stored within ClaimsManager. If ClaimsManager finds no match, it may add a department record.
	10	464	473	R	N	BillPrvSpec	Billing provider specialty. This identifier matches a specialty record stored within ClaimsManager. If Claims-Manager finds no match, it will add a specialty record.
	10	474	483	O	N	BillPrvDegreeID	
	10	484	493	O	N	BillPrvUPIN	
	20	494	513	R	N	Pri_PayID	Primary Payer or FSC identifier.
	20	514	533	O	N	Sec_PayID	Secondary Payer or FSC identifier.
	3	534	536	O	N	TOS	Type of service.
	5	537	541	R	N	Units	Number of units for the line item.
2	20			R	Y	IcdCode	ICD code.

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
3	5			O	Y	Modifier	
4	0-255			O	N	UserDefinedField1	Y/N flag, indicating sensitive record.
5	0-255			O	N	UserDefinedField2	Name of the Coder
6	0-255			O	N	UserDefinedField3	Name of the Biller
7	0-255			O	N	UserDefinedField4	Not in use
8	0-255			O	N	UserDefinedField5	Not in use
9	0-255			O	N	UserDefinedField6	Not in use
10	0-255			O	N	UserDefinedField7	Not in use
11	0-255			O	N	UserDefinedField8	Not in use
12	0-255			O	N	UserDefinedField9	Not in use
13	0-255			O	N	UserDefinedField10	Not in use
14	0-255			O	N	UserDefinedField11	Not in use
15	0-255			O	N	UserDefinedField12	Not in use
16	0-255			O	N	UserDefinedField13	Not in use
17	0-255			O	N	UserDefinedField14	Not in use
18	0-255			O	N	UserDefinedField15	Not in use
19	0-255			O	N	UserDefinedField16	Not in use
20	0-255			O	N	UserDefinedField17	Not in use
21	0-255			O	N	UserDefinedField18	Not in use
22	0-255			O	N	UserDefinedField19	Not in use
23	0-255			O	N	UserDefinedField20	Not in use

SEQ	LEN	BEG	END	OPT	RPT	ELEMENT NAME	COMMENT
24	0-255			O	N	UserDefinedField21	Not in use
25	0-255			O	N	UserDefinedField22	Not in use
26	0-255			O	N	UserDefinedField23	Not in use
27	0-255			O	N	UserDefinedField24	Not in use
28	0-255			O	N	UserDefinedField25	Not in use

List Manager Component

List Template

There are 4 List Manager templates:

1 IBCI CLAIMSMANAGER CLERK WK
2 IBCI CLAIMSMANAGER MGR WK
3 IBCI CLAIMSMANAGER SKIP LIST
4 IBCI CLAIMSMANAGER WK BROWSE

Protocols

There are 11 Protocols:

1 IBCI BLANK PROTOCOL
2 IBCI CLAIMSMANAGER CANCEL BILL
3 IBCI CLAIMSMANAGER EXIT
4 IBCI CLAIMSMANAGER OVERRIDE
5 IBCI CLAIMSMANAGER RE-EDIT
6 IBCI CLERK WORKSHEET SCREEN MENU
7 IBCI SELECT BILLS
8 IBCI SEND ALL
9 IBCI SEND NON-AUTH ONLY
10 IBCI SKIP LIST MENU
11 IBCI WORKSHEET SCREEN MENU

External Relations

Platform Requirements

VistA System:

A fully patched and complete VistA system is required, running Integrated Billing (IB) Version 2.0.

Ingenix ClaimsManager System:

Ingenix ClaimsManager Version 3.0.2 (or later version)

Hardware Requirements

A PC is needed for the ClaimsManager server. This PC must meet the requirement set forth by Ingenix n their document entitled “ClaimsManager 3.0 Hardware Deployment”. This PC must also be a dedicated PC acting only as the ClaimsManager server.

There will be a one-for-one relationship between a facility’s VistA system and a ClaimsManager server.

In order to communicate with the ClaimsManager server using TCP/IP, the TCP/IP address for the server on which the Ingenix ClaimsManager application resides must be stored in the VistA system. Vista shall not attempt to transmit claims to the ClaimsManager system unless a valid, system recognizable TCP/IP address is present in VistA. Interface specifics are stored in the IB SITE PARAMETERS (350.9) file.

Space Requirements

When the temporary data is deleted, the static data stored in file 351.9 will require approximately 1080 bytes of space per entry.

Internal Relations

Namespace

The IBCI namespace has been assigned for all routines, options etc. associated with this interface.

File Numbers

The file numbers and globals are listed below:

File #	Global
351.9	^IBA
351.91	^IBA

Variables

The message building process will be executed many times per hour/day. Therefore the code has been written to make it's execution as efficient as possible. In order to make the execution faster, the use of significant variable names was used to reduce the amount of comment lines within the routines. Following is a list of the significant variables used in the routines IBCIMSG and IBCIMSG1.

Variable List for IBCIMSG

Variable	Description
IBCIAPID	Alternate Patient ID (will always be null)
IBCICL	Bill Claim number
IBCICLNP	Bill Claim number without padding (for subscript use)
IBCIDOB	Patient Date of Birth
IBCIEBID	Ext Batch ID (we use date/time stamp)
IBCIET	Entry date/time
IBCIIEN	IEN (will = IBIFN)
IBCIPID	Patient ID (SSN)
IBCIPTFI	Patient's First Name
IBCIPTLA	Patient's Last Name
IBCIPTMI	Patient's Middle Name
IBCIRPDE	Referring Physician Department
IBCIRPDI	Referring Physician Degree ID
IBCIRPFI	Referring Physician First Name
IBCIRPID	Referring Physician ID (IEN for file 200)

IBCIRPLA	Referring Physician Last Name
IBCIRPMI	Referring Physician Middle Name
IBCIRPSP	Referring Physician Specialty
IBCIRPTI	Referring Physician Title
IBCIRPUP	Referring Physician UPIN
IBCISEX	Patient's Gender
IBIFN	IEN of bill in 399 and 351.9
II	variable used in loop
NODE3	variable to capture all data on node 3 in file 399
NODE4	variable to capture all data on node 4 in file 399
X	Variable to send data to utilities for checks and padding
X1	Variable to send data to utilities for checks and padding
X4	Variable to send data to utilities for checks and padding
Y	Variable returned from utilities

Variable List for IBCIMSG1

Variable	Description
CT	Variable for an incremental counter
I	Variable for looping
IBCIAPC	Adjusted Procedure Code
IBCIBDOS	Beginning Date of Service
IBCIBPDE	Billing Provider Department
IBCIBPDI	Billing Provider Degree ID
IBCIBPFI	Billing Provider First Name
IBCIBPID	Billing Provider ID (IEN for file 200)
IBCIBPLA	Billing Provider Last Name
IBCIBPMI	Billing Provider Middle Name
IBCIBPSP	Billing Provider Specialty
IBCIBPTI	Billing Provider Title
IBCIBPUP	Billing Provider UPIN
IBCICLNP	Bill Claim number without padding (for subscript use)
IBCICPT	CPT Modifier
IBCIEDOS	Ending Date of Service
IBCILSEG	Line Segment Number
IBCILSTA	Line Status
IBCIOGID	Org Group ID
IBCIOID	Org ID
IBCIPAC	Pre Authorization Code
IBCIPOS	Place of Service
IBCIPPID	Primary Payer ID
IBCISAMT	Submitted Amount
IBCISPAI	Secondary Payer ID
IBCISPC	Submitted Procedure Code
IBCISPDE	Service Provider Department
IBCISPDI	Service Provider Degree ID
IBCISPFI	Service Provider First Name

IBCISPID	Service Provider ID (IEN for file 200)
IBCISPLA	Service Provider Last Name
IBCISPMI	Service Provider Middle Name
IBCISPSP	Service Provider Specialty
IBCISPTI	Service Provider Title
IBCISPUP	Service Provider UPIN
IBCITOS	Type of Service
IBCIUNIT	Number of Units
IBCIXLID	External Line ID
IBIFN	IEN for file 399 and 351.9
NODE50	Variable for node 5,D1,0 in file 351.9
NODE51	Variable for node 5,D1,1 in file 351.9
NODE 52	Variable for node 5,D1,2 in file 351.9
U	"^"
X	Variable to send data to utilities for checks and padding
X1	Variable to send data to utilities for checks and padding
X4	Variable to send data to utilities for checks and padding

When calling ST2^IBCIST to send a claim, 4 variables will always be returned:

IBCISNT - identifies where it was sent from
IBCIERR - error code if error condition
IBCISTAT - claim status in 351.9
IBCIREDT - re-edit flag

Package-wide Variables

The only package-wide variable used by the ClaimsManager interface, is IBIFN. This variable is used throughout the IB package to identify the IEN of the claim.

Package Security

General Security

1. Integrated Billing files may only be updated through distributed options.
2. Per VHA Directive 10-93-142 regarding security of software that affects financial systems, most of the IB routines may not be modified. The third line of routines that may not be modified will be so noted.
3. According to the same directive, most of the IB Data Dictionaries may not be modified.

Security Keys

Security Key Name	Description
IBCI CLAIMSMANAGER OVERRIDE	Restricts the ability to override errors.
IBCI CM MULTIPLE CLAIM SEND	Restricts access to the IBCI MULTIPLE CLAIM SEND option.
IBCI CLAIMSMANAGER ASSIGN	Restricts the ability to assign claims.

Interfacing

Interfacing between the two systems is accomplished by opening a TCP/IP port, transmitting data to the ClaimsManager system, waiting for a response, receiving data based on the processing of the claim, then closing the TCP/IP port.

File Security

The following is a list of recommended VA FileMan access codes associated with each file contained in the KIDS build for the ClaimsManager interface.

File #	File Name	DD	RD	WR	DEL	LAYGO	AUDIT
350.9	IB SITE PARAMETERS	@	@	@	@	@	@
351.9	CLAIMSMANAGER BILLS	@	@	@	@	@	@
351.91	CLAIMSMANAGER STATUS	@	@	@	@	@	@

Glossary

ADPAC	Automated Data Processing Applications Coordinator
AR	Accounts Receivable This is a system of bookkeeping necessary to track VAMC debt collection.
CPT	Current Procedural Terminology A coding method developed by the American Hospital Association to assign code numbers to procedures which are used for research, statistical, and reimbursement purposes.
Data Field	A block component that is the means by which data from *VIS*TA is printed to the form. The data is obtained at the time the form is printed (i.e., it is not stored with the form) and can be particular to the patient. A data field can have subfields, which are conceptually a collection of related data fields. Attributes include label, label type (underlined, bold, invisible), position, data area, data length and position (area on the form allocated to the data), item number, and package interface (the routine used to get the data).
Entry Action	An attribute of a package interface. It is MUMPS code that is executed before the interface's entry point is executed.
EP	Expert Panel
Exit Action	An attribute of a package interface. It is MUMPS code that is executed after the interface's entry point is executed.
HCFA	Health Care Finance Administration
HCFA-1500	AMA approved health insurance claim form used for outpatient third party billings.
IB	Integrated Billing
ICD-9	International Classification of Diseases, the Ninth Modification A coding system designed by the World Health Organization to assign code numbers to diagnoses and procedures for statistical, research, and reimbursement purposes.
Item Number	An attribute that must be specified when defining a data field if the data field's package interface returns a list. The

	item number is used to specify which item on the list should be printed to the data field. For example, there is a package interface for returning service-connected conditions. The first data field created for a form for displaying a service-connected condition would specify item number one.
MCCR	Medical Care Cost Recovery The collection of monies by the Department of Veterans Affairs (VA).
Provider	A person, facility, organization, or supplier which furnishes health care services.
Protected Variable	An attribute of a package interface. It is a variable that should be "newed" before calling the interface's entry point.
Required Variable	An attribute of a package interface. It is a variable that must exist in order for the interface's entry point to be called.
Security Code	A code assigned to each user identifying him/her specifically to the system and allowing him/her access to the functions/ options assigned to him/her.
Security Key	Used in conjunction with locked options or functions. Only holders of this key may perform these options/functions. Used for options which perform a sensitive task.
Selection	A component of a selection list. It is a single entry on the list. It is stored with the form and is usually data taken from a file in *VIS*TA such as a CPT code with its description.
Subfield	A component of a data field. It can display a single value, whereas a data field can be used to display a collection of related values. Attributes include those for the label and the area on the form to print the data. Also, for package interfaces that return records that have multiple values, the particular data must be specified.
Third Party Billings	Billings where a party other than the patient is billed.